Early Intervention Program

Department of Public Health
Bureau of Family Health & Nutrition

EIIS Autism Specialty

Child's Name: _____ EI DPH ID: __ __ / __ __ __ __ __ -- __

* Date of Diagnosis: ___ / ___ / _____ Age: _____

* Confirmed ASD diagnosis (select only one)

- ☐ Asperger Syndrome
- ☐ Autism
- ☐ Childhood Disintegrative Disorder
- ☐ Pervasive Developmental Disorder (PDD)
  (includes Autism Spectrum Disorder)
- ☐ Rett Syndrome

* Diagnostician Name: _____

* Specialty (select only one)

- ☐ Physician
- ☐ Licensed Psychologist

* Child participates in the DSS Waiver Program? (MassHealth eligible children only) ☐

* DIRECT TREATMENT SERVICES ONLY

Child receives intensive home-based services for Autism from your EI program? ☐

Specialty Providers (select all that apply)
(Do not check if received ONLY an Intake service)

	Date of SSP Referral
☐ Beacon Services	___ / ___ / _____
☐ Building Blocks (NE Arc)	___ / ___ / _____
☐ Children Making Strides	___ / ___ / _____
☐ HMEA	___ / ___ / _____
☐ LEAP	___ / ___ / _____
☐ May Center	___ / ___ / _____
☐ New England Center for Children	___ / ___ / _____
☐ Pediatric Developmental Center	___ / ___ / _____
☐ REACH – ServiceNet	___ / ___ / _____
☐ Other: _____	___ / ___ / _____